Example 269a

Texas Department Of Health
FINANCIAL STATUS REPORT
269A

1100 West 49th Street
Austin, Texas 78756-3199

Grants Management Division
Phone (512) 458-7520

1. **TDH Program:** HIV/EDUC		6. **Contractor Name:** Name of Performing Agency
2. **Payee Acct. No.:**	3. **Final Report:** [x] Yes [ ] No	7. **TDH Doc. No. + Att. No.:** 7788899966 97-03
4. **Payee 14 Digit Vendor ID No.:** 77788899966655		8. **Basis: [x] Cash [ ] Accrual**
5. **Payee Name:** As stated on contract **Address:** As stated on contract **City, ST, Zip:** As stated on contract		9. **Contract Term: (Month/Day/Year)** **From: 10/01/97 To: 09/30/97**
		10. **Period Covered by this Report:** **From: 07/01/98 To: 09/30/98**

11. Budget Categories		(a) Approved Budget	(b) Project Cost this Period	(c) Cumulative Project Cost	(d) Balance
a. Personnel	[x]	$ 10,000.00	3,500.00	13,100.00	(3,100.00)
b. Fringe Benefits	[x]	3,500.00	1,000.00	3,900.00	(400.00)
c. Travel	[x]	1,500.00	0.00	1,600.00	(100.00)
d. Equipment	[ ]	2,000.00	0.00	2,000.00	0.00
e. Supplies	[x]	1,000.00	200.00	1,400.00	(400.00)
f. Contractual	[ ]	8,000.00	400.00	7,700.00	300.00
g. Other	[ ]	5,000.00	500.00	4,800.00	200.00
h. Total Direct Charge		31,000.00	5,600.00	34,500.00	(3,500.00)
i. Indirect Charges	[ ]	3,200.00	0.00	3,200.00	0.00
j. Total Charges		$ 34,200.00	5,600.00	37,700.00	(3,500.00)
k. PI Expended			3,200.00	3,500.00	

CERTIFICATION: I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.

Signature of Authorized Certifying Official Signature of Executive Director or Chief Financial Officer	Date Submitted ___/___/___
Typed or Printed Name and Title	Telephone ( )___-_____

12.a. Prior Year PI Carryover.....	$	1,500.00
b. Current Year PI Collected.....	$	3,700.00
c. Total PI (prior year carryover & current year collected).....	$	5,200.00

* Item 11k (c) must be equal to or greater than Item 12a by end of contract.

[ ] Indicate with an X each category where Program Income (PI) has been expended.

A1.1

Texas Department Of Health
FINANCIAL STATUS REPORT
269A

1100 West 49th Street **Grants Management Division**
Austin, Texas 78756-3199 **Phone (512) 458-7520**

1. **TDH Program:**		6. **Contractor Name:**
2. **Payee Acct. No.:**	3. **Final Report:** [ ] Yes [ ] No	7. **TDH Doc. No. + Att. No.:**
4. **Payee 14 Digit Vendor ID No.:**		8. **Basis: [ ] Cash [ ] Accrual**
5. **Payee Name:** **Address:** **City, ST, Zip:**		9. **Contract Term: (Month/Day/Year)** **From: To:**
		10. **Period Covered by this Report:** **From: To:**

11. Budget Categories	(a) Approved Budget	(b) Project Cost this Period	(c) Cumulative Project Cost	(d) Balance
a. Personnel [ ]				
b. Fringe Benefits [ ]				
c. Travel [ ]				
d. Equipment [ ]				
e. Supplies [ ]				
f. Contractual [ ]				
g. Other [ ]				
h. Total Direct Charge				
i. Indirect Charges [ ]				
j. Total Charges				
k. PI Expended				

CERTIFICATION: I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.

Signature of Authorized Certifying Official	Date Submitted ___/___/___
Typed or Printed Name and Title	Telephone ( )___-_____

12.a. Prior Year PI Carryover.....

b. Current Year PI Collected.....

c. Total PI (prior year carryover & current year collected)..... $

* Item 11k (c) must be equal to or greater than Item 12a by end of contract.

[ ] Indicate with an X each category where Program Income (PI) has been expended.

TDH Form GC-4a (269a) Revised 5/95

INSTRUCTIONS FOR QUARTERLY/FINAL FINANCIAL STATUS REPORT
FORM 269A (TDH FORM GC-4a)

SECTION	ENTRY
1	TDH Program: TDH program name as indicated in the contract attachment
2	Payee Acct. No.: Contractor's account number or other identifying number.
3	Final Report: Check "No" for quarterly reports; check "Yes" for final report.
4	Payee 14 Digit Vendor ID No.: Number assigned by the State of Texas Comptroller's Office.
5	Payee: Name, Address, City, State, and Zip Code of authorized contracting entity (office responsible for accounting control). This information must coincide with the State Comptroller's Office records and Vendor ID number in Section 4 above.
6	Contractor Name: Legal name of contractor
7	TDH Doc. No. & Att. No.: The contract number assigned by TDH.(e.g. 7460002334-97-07 or 7460002334A97-07) DO NOT confuse the Attachment No. with the change numbers for the contract amendments.
8	Basis: Indicate whether report is prepared on "Cash" or "Accrual" basis accounting.
9	Contract Term: Contract period (e.g., 9/1/93 - 8/31/94).
10	Period Covered by this Report: Month, day and year for the beginning and ending of the contract quarter should coincide with Section 11, Column (b) (Project Cost this Period); (e.g., 9/1/93-11/30/93, 12/1/93-2/28/94, 3/1/94- 5/31/94, and 6/1/94-8/31/94).
11	Budget categories and Expenditures by category
11(a)	Approved Budget: Approved budget exactly as indicated in fully executed contract.
11(b)	Project Cost this Period: Program outlays for the quarterly reporting period. Also, include TDH's proportionate share of Program Income expended and indicate with an "X" by each applicable category.
11(c)	Cumulative Project Cost: Total program outlays through the reporting period. Also, include TDH's proportionate share of Program Income expended and indicate with an "X" by each applicable category.
11(d)	Balance: Subtract Cumulative Project Cost (Column c) from Approved Budget (Column a).
12	Program Income
12(a)	Prior Year PI Carryover: Amount of carryover, if any, from prior year final Financial Status Report Form 269a
12(b)	Current Year PI Collected: TDH's proportionate share of Program Income collected from the beginning of the contract term through the current report period.
12(c)	Total PI (prior year carryover & current year collected): Represents the total of the prior year PI carryover plus the current year PI collected (item a. plus item b.).

Send Reports to: Texas Department of Health
Grants Management Division
1100 West 49th Street
Austin, Texas 78756-3199

TEXAS DEPARTMENT OF HEALTH

REQUEST FOR ADVANCE OR REIMBURSEMENT

Approved by Office of Management and Budget, No. 80-RO183

Page of Pages

1. Type of payment requested

a. "X" one or both boxes ☐ Advance ☐ Reimbursement

b. "X" the applicable box ☐ Final ☐ Partial

2. Basis of Request ☐ Cash ☐ Accrual

3. FEDERAL SPONSORING AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH THIS REPORT IS SUBMITTED

4. FEDERAL GRANT OR OTHER IDENTIFYING NUMBER ASSIGNED BY FEDERAL AGENCY

5. PARTIAL PAYMENT REQUEST NUMBER FOR THIS REQUEST

6. VENDOR ID#

7. RECIPIENT'S ACCOUNT NUMBER OR IDENTIFYING NUMBER

8. PERIOD COVERED BY THIS REQUEST

FROM (mo/da/yr) TO (mo/da/yr)

9. RECIPIENT ORGANIZATION

Name:

Number/Street

City/State/Zip

10. PAYEE (Where check is to be sent if different from item #9)

Name

Number/Street

City/State/Zip

11. COMPUTATION OF AMOUNT OF REIMBURSEMENTS/ADVANCES REQUESTED

PROGRAMS/FUNCTIONS/ACTIVITIES	(a)	(b)	(c)	TOTAL
a. Total program outlays to date (as of date)	$	$	$	$
b. *Less:* Cumulative program income				
c. Net program outlays (line **a** minus line **b**)				
d. Estimated net cash outlays for advance period				
e. Total (sum of lines **c** and **d**)				
f. Non-Federal share of amount on line **e**				
g. Federal share of amount on line **e**				
h. Federal payments previously requested				
i. Federal share now requested (line **g** minus line **h**)				
j. Advances required by month, when requested by Federal grantor agency for use in making pre-scheduled advances — *1st Month*				
2nd Month				
3rd Month				

12. ALTERNATE COMPUTATION FOR ADVANCES ONLY

a. Estimated Federal cash outlays that will be made during period covered by the advance	$
b. *Less:* Estimated balance of Federal cash on hand as of beginning of advance period	
c. Amount requested (line **a** minus line **b**)	$

13. CERTIFICATION

I certify that, to the best of my knowledge and belief, the data included on this form are correct and that all outlays were made in accordance with the grant conditions or other agreements, and that payment is due and has not been previously requested.

Signature of Authorized Certifying Official | *Date Request Submitted*

Typed or Printed Name and Title

Telephone | *A/C* | *Number* | *Extension*

Standard Program Income (PI) Calculation

PI Carried Forward from Prior Year _____

Plus: PI Collected this Year _____

Total PI Available _____

Less: PI Expended this Year _____

PI to be Carried Forward _____

Title X Non-Federal Share

Non-Federal Share Carried Forward From Prior Year[1] _____

Plus: Patient Fees _____

Plus: Title XX _____

Plus: Title XIX _____

Plus: Other _____

Plus: In-Kind _____

Plus: Agency Funds _____

Total Non-Federal Share Available _____

Less: Current Year Non-Federal Share (Box 11, Line f)[1,2] _____

Non-Federal Share to be Carried Forward[1] _____

[1] Required only on the final Form 270.
[2] Must be equal to or greater than Prior Year Non-Federal Share Carryover

Title V Fee-for-Service & Title XX Stand-Alone

1) Total Reimbursable Services	$150,000.00
Less: TDH Payments	145.000.00
Add'l Services Provided	5,000.00
2) PI Carried Forward from Prior Year	7,500.00
Plus: PI Collected this Year	15,000.00
Total PI Available	22,500.00
Less: PI expenditures[2]	5,000.00
PI to be carried forward	17,500.00

Agency does not have Title X and Title XX at the same location

Lesser of Add'l Services Provided from Section 1 or Total PI Available from Section 2

270-101 EXHIBIT 3STANDARD FORM 270 (7-76)
GC-10Proscribed by Office of Management and Budget
CIRCULARS NO. A-102 and A-110

Instructions for Completion of
Form 270 - Request for Advance or Reimbursement
Title V Individually-Based Services (aka Fee) Contracts

Texas Department of Health Title V Individually-Based Services contracts require an end-of-the year Form 270, Request for Advance or Reimbursement, which has been revised to accomodate Title V information. Title V contractors are required to complete boxes 1b, 2, 6, 7 (TDH Document Number), 8, 9, and 13 and the Title V Fee-for-Service & Title XX Stand-Alone section at the bottom of the form. The following is a set of definitions for the terms used in the Title V Fee-for-Service & Title XX Stand-Alone section and an example of a completed section.

Program Income (PI)
Co-pay or other fees collected from Title V clients for services reimbursed by Title V. In the case of Title V, this does not include Medicaid reimbursements since Medicaid-covered services are not reimbursed under Title V.

Total Reimbursable Services
Title V-approved charges for ALL Title V-allowable services provided to ALL Title V-eligible clients during the contract term.

TDH Payments
Reimbursements received from TDH for services provided during the contract term.

Add'l Services Provided
The difference between the Total Reimbursable Services and TDH Payments, which is the maximum amount of services which can be covered by PI.

PI Carried Forward from Previous Year
PI remaining at the end of the previous contract which must be expended by the end of the current contract term.

PI Collected this Year
PI collected during the contract term.

Total PI Available
Sum of PI Carried Forward from Prior Year and PI Collected this Year.

PI Expenditures
PI expended during the contract term to provide additional, allowable services to Title V-eligible clients. This amount is the lesser of Total PI Available and Add'l Services Provided from Section 1.

PI to be carried forward
Difference between Total PI Available and PI expenditures. PI expenditures for the subsequent contract term must be AT LEAST this amount.

Example:
Abacab County Health Department received a $100,000 Title V Individually Based Services contract from TDH. They provided $120,000 in Title V-Allowable Services and were reimbursed $100,000, the entire contract amount. They collected $5,000 in PI and carried forward $1,000 in PI. Based on this information, their Title V Fee-for-Service & Title XX Stand-Alone section would look as follows:

1)	Total Reimbursable Services	$120,000.00
	Less: TDH Payments	($100,000.00)
	Add'l Services Provided	**$20,000.00**
2)	PI Carried Forward from Prior Year	$1,000.00
	Plus: PI Collected this Year	$5,000.00
	Total PI Available	$6,000.00
	Less: PI Expenditures	($6,000.00)*
	PI to be carried forward	**$0.00**

* $20,000 additional services provided but only $6,000 PI available to expend.

TEXAS DEPARTMENT OF HEALTH

REQUEST FOR ADVANCE OR REIMBURSEMENT

Approved by Office of Management and Budget, No. 80-RO183

Page of Pages

1. Type of payment requested

a. "X" one or both boxes
☐ Advance ☐ Reimbursement

b. "X" the applicable box
☐ Final ☐ Partial

2. Basis of Request
X☐ Cash
☐ Accrual

3. FEDERAL SPONSORING AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH THIS REPORT IS SUBMITTED	**4.** FEDERAL GRANT OR OTHER IDENTIFYING NUMBER ASSIGNED BY FEDERAL AGENCY	**5.** PARTIAL PAYMENT REQUEST NUMBER FOR THIS REQUEST

6.VENDOR ID#	**7.** RECIPIENT'S ACCOUNT NUMBER OR IDENTIFYING NUMBER	**8.** PERIOD COVERED BY THIS REQUEST
17598765432100	7598765432 9701	FROM (mo/da/yr) 4/1/97 TO (mo/da/yr) 6/30/97

9. RECIPIENT ORGANIZATION

Name: Abacab County

Number/Street 123 XYZ Street

City/State/Zip Genesis, TX 70000

10. PAYEE (Where check is to be sent if different from item #9)

Name

Number/Street

City/State/Zip

11. COMPUTATION OF AMOUNT OF REIMBURSEMENTS/ADVANCES REQUESTED

PROGRAMS/FUNCTIONS/ACTIVITIES	(a)	(b)	(c)	TOTAL
a. Total program outlays to date (as of date)	$101,110.00	$	$	$
b. *Less:* Cumulative program income	N/A			
c. Net program outlays (line **a** minus line **b**)	$101,110.00			
d. Estimated net cash outlays for advance period				
e. Total (sum of lines **c** and **d**)	$101,110.00			
f. Non-Federal share of amount on line **e**	$55,487.00			
g. Federal share of amount on line **e**	$45,623.00			
h. Federal payments previously requested	$30,597.00			
i. Federal share now requested (line **g** minus line **h**)	$15,026.00			
j. Advances required by month, when requested by Federal grantor agency for use in making pre-scheduled advances — *1st Month*				
2nd Month				
3rd Month				

12. ALTERNATE COMPUTATION FOR ADVANCES ONLY

a. Estimated Federal cash outlays that will be made during period covered by the advance	$
b. *Less:* Estimated balance of Federal cash on hand as of beginning of advance period	
c. Amount requested (line **a** minus line **b**)	$

13. CERTIFICATION

I certify that, to the best of my knowledge and belief, the data included on this form are correct and that all outlays were made in accordance with the grant conditions or other agreements, and that payment is due and has not been previously requested.

Signature of Authorized Certifying Official | *Date Request Submitted*

Typed or Printed Name and Title

Telephone *A/C* *Number* *Extension*

Standard Program Income (PI) Calculation

PI Carried Forward from Prior Year _____

Plus: PI Collected this Year _____

Total PI Available _____

Less: PI Expended this Year _____

PI to be Carried Forward _____

Title X Non-Federal Share

Non-Federal Share Carried Forward From Prior Year[1]	$ 55,487.00
Plus: Patient Fees	10,421.00
Plus: Title XX	30,397.50
Plus: Title XIX	6,125.70
Plus: Other	0.00
Plus: In-Kind	0.00
Plus: Agency Funds	0.00
Total Non-Federal Share Available	$102,431.20
Less: Current Year Non-Federal Share (Box 11, Line f)[1,2]	N/A
Non-Federal Share to be Carried Forward[1]	N/A

[1] Required only on the final Form 270.
[2] Must be equal to or greater than Prior Year Non-Federal Share Carryover

Title V & Title XX Stand-Alone

1) Total Reimbursable Services _____

Less: TDH Payments _____

Add'l Services Provided _____

2) PI Carried Forward from Prior Year _____

Plus: PI Collected this Year _____

Total PI Available _____

Less: PI expenditures[2] _____

PI to be carried forward _____

Agency does not have Title X and Title XX at the same location

FSR FORM 270 - TITLE X CONTRACT - Instructions

Items 1, 3, 5, 9, 10, 11c, 11e, 11g, 11i, and 12 are self explanatory. (All references to "Federal" are synonymous to "State").

SECTION	ENTRY
2	Basis of Request: Not applicable
4	Federal Grant or Other Identifying Number Assigned by Federal Agency: The number assigned to the contract by TDH.
6	Employer Identification Number: 14 digit number assigned by the State Comptroller's Office
7	Recipient's Account Number or Identifying Number: This space is reserved for contractor's account number or other identifying number.
8	Period Covered by this Request: Month, day and year for the beginning and ending of the contract term.
11	Column (a) Enter applicable TDH program name at the top of column
11(a)	Total program outlays to date (As of Date) and Total: Month, day and year of the contract period. Total program outlays to date (cumulative expenditures made to the program/activity). This amount should equal amount on line 11j, column c, on the last (4th) quarterly Form 269a. This amount is to include actual cash disbursements, indirect expenses, and the amount of cash advances and payments made to subcontractors.
11(b)	Less: Cumulative program income - Not applicable
11(d)	Estimated net cash outlays for advance period: Not applicable
11(f)	Non-Federal share of amount on line e: contractor's share of program expenditures. This amount should be be greater than or equal to the Non-Federal Share carried forward.)
11(h)	Federal payment previously requested: Total of monthly vouchers submitted to TDH.
11(j)	Advances required by month: Not applicable.
12	Alternate Computation for Advances Only: Not applicable.
13	Certification: Complete the certification before submitting this report.
Non-Federal Share	Complete the lower center section of the Form 270 which is titled "Title X Non-Federal Share" with the appropriate information. This information should include prior year's Non-Federal carried forward and any other program income generated.

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TEXAS DEPARTMENT OF HEALTH

REQUEST FOR ADVANCE OR REIMBURSEMENT

Approved by Office of Management and Budget, No. 80-RO183

Page of Pages

1. Type of payment requested

a. "X" one or both boxes
☐ Advance ☐ Reimbursement

b. "X" the applicable box
☐ Final ☐ Partial

2. Basis of Request
X☐ Cash
☐ Accrual

3. FEDERAL SPONSORING AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH THIS REPORT IS SUBMITTED	**4.** FEDERAL GRANT OR OTHER IDENTIFYING NUMBER ASSIGNED BY FEDERAL AGENCY	**5.** PARTIAL PAYMENT REQUEST NUMBER FOR THIS REQUEST

6.VENDOR ID#	**7.** RECIPIENT'S ACCOUNT NUMBER OR IDENTIFYING NUMBER	**8.** PERIOD COVERED BY THIS REQUEST
17598765432100	7598765432 9701	FROM (mo/da/yr) 4/1/97 TO (mo/da/yr) 6/30/97

9. RECIPIENT ORGANIZATION

Name: Abacab County

Number/Street 123 XYZ Street

City/State/Zip Genesis, TX 70000

10. PAYEE (Where check is to be sent if different from item #9)

Name

Number/Street

City/State/Zip

11. COMPUTATION OF AMOUNT OF REIMBURSEMENTS/ADVANCES REQUESTED

PROGRAMS/FUNCTIONS/ACTIVITIES	(a)	(b)	(c)	TOTAL
a. Total program outlays to date (as of date)	$57,000.00	$	$	$
b. *Less:* Cumulative program income	N/A			
c. Net program outlays (line **a** minus line **b**)	$57,000.00			
d. Estimated net cash outlays for advance period				
e. Total (sum of lines **c** and **d**)	$57,000.00			
f. Non-Federal share of amount on line **e**	$26,000.00			
g. Federal share of amount on line **e**	$31,000.00			
h. Federal payments previously requested	$31,000.00			
i. Federal share now requested (line **g** minus line **h**)				
j. Advances required by month, when requested by Federal grantor agency for use in making pre-scheduled advances — *1st Month*				
2nd Month				
3rd Month				

12. ALTERNATE COMPUTATION FOR ADVANCES ONLY

a. Estimated Federal cash outlays that will be made during period covered by the advance	$
b. *Less:* Estimated balance of Federal cash on hand as of beginning of advance period	
c. Amount requested (line **a** minus line **b**)	$

13. CERTIFICATION

I certify that, to the best of my knowledge and belief, the data included on this form are correct and that all outlays were made in accordance with the grant conditions or other agreements, and that payment is due and has not been previously requested.

Signature of Authorized Certifying Official — *Date Request Submitted*

Typed or Printed Name and Title

Telephone *A/C* *Number* *Extension*

Standard Program Income (PI) Calculation

PI Carried Forward from Prior Year _____

Plus: PI Collected this Year _____

Total PI Available _____

Less: PI Expended this Year _____

PI to be Carried Forward _____

Title X Non-Federal Share

Non-Federal Share Carried Forward From Prior Year[1] _____

Plus: Patient Fees _____

Plus: Title XX _____

Plus: Title XIX _____

Plus: Other _____

Plus: In-Kind _____

Plus: Agency Funds _____

Total Non-Federal Share Available _____

Less: Current Year Non-Federal Share (Box 11, Line f)[1,2] _____

Non-Federal Share to be Carried Forward[1] N/A

[1] Required only on the final Form 270.
[2] Must be equal to or greater than Prior Year Non-Federal Share Carryover

Title V & Title XX Stand-Alone

1) Total Reimbursable Services _____

Less: TDH Payments _____

Add'l Services Provided _____

2) PI Carried Forward from Prior Year _____

Plus: PI Collected this Year _____

Total PI Available _____

Less: PI expenditures[2] _____

PI to be carried forward _____

Agency does not have Title X and Title XX at the same location

FSR FORM 270 - EMS CONTRACT - Instructions

Items 1, 3, 5, 9, 10, 11c, 11e, 11g, 11i, and 12 are self explanatory. (All references to "federal" are synonymous with "state").

SECTION	ENTRY
2	Basis of Request: Not applicable
4	Federal Grant or Other Identifying Number Assigned by Federal Agency: The number assigned to the contract by TDH.
6	Employer Identification Number: 14 digit number assigned by the State Comptroller's Office
7	Recipient's Account Number or Identifying Number: This space is reserved for contractor's account number or other identifying number.
8	Period Covered by this Request: Beginning and ending dates of the contract term (MM/DD/YY)
11	Column (a) Enter applicable TDH program name at the top of column
11(a)	Total program outlays to date (As of Date) and Total: Month, day and year of the contract period. Total Program outlays to date (cumulative expenditures made to the program/activity). This amount should equal amount on line 11j, column c, on the last (4th) quarterly Form 269a. This amount is to include actual cash disbursements, indirect expenses, and the amount of cash advances and payments made to subcontractors.
11(b)	Less: Cumulative program income - Not applicable
11(d)	Estimated net cash outlays for advance period: Not applicable
11(f)	Non-federal share of amount on line e: contractor's share of program expenditures.
11(h)	Federal payment previously requested: Total of monthly vouchers submitted to TDH.
11(j)	Advances required by month: Not applicable.
12	Alternate Computation for Advances Only: Not applicable.
13	Certification: Complete the certification before submitting this report.

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Send Reports to: Texas Department of Health
Grants Management Division
1100 West 49th Street
Austin, Texas 78756-3199

TEXAS DEPARTMENT OF HEALTH

REQUEST FOR ADVANCE OR REIMBURSEMENT

Approved by Office of Management and Budget, No. 80-RO183

Page of Pages

1. Type of payment requested

a. "X" one or both boxes
☐ Advance ☐ Reimbursement

b. "X" the applicable box
☐ Final ☐ Partial

2. Basis of Request
☐ Cash
☐ Accrual

3. FEDERAL SPONSORING AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH THIS REPORT IS SUBMITTED

4. FEDERAL GRANT OR OTHER IDENTIFYING NUMBER ASSIGNED BY FEDERAL AGENCY

5. PARTIAL PAYMENT REQUEST NUMBER FOR THIS REQUEST

6. VENDOR ID#

7. RECIPIENT'S ACCOUNT NUMBER OR IDENTIFYING NUMBER

8. PERIOD COVERED BY THIS REQUEST
FROM (mo/da/yr) TO (mo/da/yr)

9. RECIPIENT ORGANIZATION
Name:
Number/Street
City/State/Zip

10. PAYEE (Where check is to be sent if different from item #9)
Name
Number/Street
City/State/Zip

11. COMPUTATION OF AMOUNT OF REIMBURSEMENTS/ADVANCES REQUESTED

PROGRAMS/FUNCTIONS/ACTIVITIES	(a)	(b)	(c)	TOTAL
a. Total program outlays to date (as of date)		$	$	$
b. *Less:* Cumulative program income				
c. Net program outlays (line **a** minus line **b**)				
d. Estimated net cash outlays for advance period				
e. Total (sum of lines **c** and **d**)				
f. Non-Federal share of amount on line **e**				
g. Federal share of amount on line **e**				
h. Federal payments previously requested				
i. Federal share now requested (line **g** minus line **h**)				
j. Advances required by month, when requested by Federal grantor agency for use in making pre-scheduled advances — *1st Month*				
2nd Month				
3rd Month				

12. ALTERNATE COMPUTATION FOR ADVANCES ONLY

a. Estimated Federal cash outlays that will be made during period covered by the advance	$
b. *Less:* Estimated balance of Federal cash on hand as of beginning of advance period	
c. Amount requested (line **a** minus line **b**)	$

13. CERTIFICATION

I certify that, to the best of my knowledge and belief, the data included on this form are correct and that all outlays were made in accordance with the grant conditions or other agreements, and that payment is due and has not been previously requested.

Signature of Authorized Certifying Official | *Date Request Submitted*

Typed or Printed Name and Title

Telephone *A/C* *Number* *Extension*

Standard Program Income (PI) Calculation

PI Carried Forward from Prior Year _____

Plus: PI Collected this Year _____

Total PI Available _____

Less: PI Expended this Year _____

PI to be Carried Forward _____

Title X Non-Federal Share

Non-Federal Share Carried Forward From Prior Year[1] _____

Plus: Patient Fees _____

Plus: Title XX _____

Plus: Title XIX _____

Plus: Other _____

Plus: In-Kind _____

Plus: Agency Funds _____

Total Non-Federal Share Available _____

Less: Current Year Non-Federal Share (Box 11, Line f)[1,2] _____

Non-Federal Share to be Carried Forward[1] _____

[1] Required only on the final Form 270.
[2] Must be equal to or greater than Prior Year Non-Federal Share Carryover

Title V & Title XX Stand-Alone[1]

1) Total Reimbursable Services _____
Less: TDH Payments _____
Add'l Services Provided _____

2) PI Carried Forward from Prior Year _____
Plus: PI Collected this Year _____
Total PI Available _____
Less: PI expenditures[2] _____
PI to be carried forward _____

[1] Agency does not have Title X and Title XX at the same location

[2] Lesser of Add'l Services Provided from Section 1 or Total PI Available from Section 2

Example - TDH Form B-13

STATE OF TEXAS

PURCHASE VOUCHER Page ___ of ___

WP5.1 (9/93)

1. Archive reference number	2. Agency No. **501**	3. Agency Name **TEXAS DEPARTMENT OF HEALTH**		4. Current document number
	5. Effective date	6. DOC date 05/16/96	7. Due date	8. Doc Agency **501**
9.Payee identification number **17598765432100**	10. PDT	11. PCC	12. Requisition number	13. Document amount **$17,000.00**
14. Payee name/address **Abacab County 123 XYZ Street Genesis, TX 70000**		15. GSC order number 16. Lease number	17. AGENCY USE FUND ___ BUDGET ___ CAT. ___ SERV DATE ___ General ___ or Program ___ Activity Code ___	

18. SFX 001	Ref Doc	SFX	M	TC	Index	PCA	AY	COBJ	AOBJ	Amount	R
	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
	Invoice number			Description			AGENCY USE				
18. SFX 002	Ref Doc	SFX	M	TC	Index	PCA	AY	COBJ	AOBJ	Amount	R
	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
	Invoice number			Description			AGENCY USE				
18. SFX 003	Ref Doc	SFX	M	TC	Index	PCA	AY	COBJ	AOBJ	Amount	R
	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
	Invoice number			Description			AGENCY USE				

19. SER/DEL DATE	20. DESCRIPTION OF GOODS OR SERVICES	21. QUANTITY	22. UNIT PRICE	23. AMOUNT
Month of service	**Reimbursement for services as specified in the contract between the Texas Department of Health andABacab County Health Department** **Program: COPC** **9/1/96 to 8/31/97** **Entity: Agency Entity Type** **TDH Doc No, Year, & Attachment: 7598765432 97-01**		**Less: Advance Reduction**	**$22,000.00** **5,000.00** **$17,000.00**

24. Contact name **Ida Allthework**	Phone (Area code and number) **(512)555-0000**	25. Entered by

26. I approve this voucher for payment. The above goods or services correspond in every particular with the contract under which they were purchased. The invoice for the goods or services is correct. This payment complies with the General Appropriations Act.

Approved sign here ▸	Phone (Area code and number)	Date
Fiscal Approved sign here ▸	Phone (Area code and number)	Date

INSTRUCTIONS FOR MONTHLY REIMBURSEMENT REQUEST USING A STATE OF TEXAS PURCHASE VOUCHER (TDH FORM B-13)

SECTION	*ENTRY*
6. Order (document) date	Date voucher is submitted for payment
9. Payee I.D. No.	Performing Agency's 14 digit code number assigned by the State Comptroller's Office
14. Payee name/address	Name, Address, City, State, Zip of the Performing Agency. This information must coincide with **Section 9** (Payee I.D. No.) and State Comptroller's Office records or issuance of the payment warrant may be delayed
19. Ser/Del Date	The month in which costs were incurred (accrual basis) or costs were paid (cash basis). In the case of advance payment, the date should be the first month of the contract term
20. Description of Goods or Services	
Reimbursement statement	Reimbursement for services as specified in the contract between the Texas Department of Health and (name of Performing Agency). Contract term: __/__/__ thru __/__/__
OR	
Advance statement	Advance Payment for services to be performed as specified in the contract between the Texas Department of Health and (name of Performing Agency) Contract term: __/__/__ thru __/__/__
AND	
Program	Please select the appropriate TDH Program.
Type of Entity	Select the entity type which best describes your organization: **College or University, Government, Non-profit , For profit or State Agency**
TDH Document No./ Attachment No.	The number assigned to the contract by TDH
13 Document Amount	The net amount for which you are billing TDH for the period indicated in Section 19
21 & 22. Quantity/Unit Price	Required on fee for service contracts

23. Amount	The total amount you are billing TDH for the period indicated in Section 19 Less: The amount of any refunds (if any). Explanation in Section #20 Less: The amount of advance reduction (if any) The net amount (same as #13 above)
24. Contact name	Enter name and phone number of person responsible for this account

ONLY THE ABOVE SECTIONS WILL BE COMPLETED BY THE CONTRACTOR. ALL OTHER SECTIONS, *INCLUDING SECTIONS #25 & 26*, SHOULD BE LEFT BLANK.

Address vouchers to: **Texas Department of Health**
Grants Management Division
1100 West 49th Street
Austin, Texas 78756-3199

EMPLOYEE TIME AND ATTENDANCE RECORD

NAME _____ TITLE _____ PERIOD COVERED _____

PROJECT NAME/ACCT. #	TOTAL HOURS	<<---------- DATES ---------->																					
TOTAL HOURS WORKED																							
SICK LEAVE																							
VACATION																							
HOLIDAY																							
OTHER																							
TOTAL NON-PRODUCTIVE HRS																							
TOTAL HOURS																							
COMP TIME EARNED																							

I CERTIFY THAT THE TIME REFLECTED ABOVE AND THE DISTRIBUTION OF THAT TIME IS CORRECT TO THE BEST OF MY BELIEF AND KNOWLEDGE.

EMPLOYEE'S SIGNATURE _____ SUPERVISOR'S SIGNATURE _____

TRAVEL EXPENSE VOUCHER

(Expenses for one individual - one trip only)

TRIP DATES: FROM: _____ TO_____

EMPLOYEE NAME & TITLE: _____

DESTINATION: _____

PURPOSE OF TRIP: _____

_____

_____

_____

INDIVIDUALS CONTACTED: _____

EXPENSES INCURRED (attach original receipts - credit card receipts not acceptable) :

LODGING	
MEALS	
CAR RENTAL	
RENTAL CAR GASOLINE	
PERSONAL VEHICLE MILEAGE (attach Mileage Voucher)	
PARKING FEES	
OTHER	
TOTAL EXPENSES	
LESS: TRAVEL ADVANCE RECEIVED	
AMOUNT DUE TO / FROM EMPLOYEE	

ACCOUNTS/PROGRAMS TO BE CHARGED	AMOUNT	ALLOCATION BASIS
TOTAL		

I certify that the above information is true & correct and the expenses were incurred solely for the purpose(s) described above.

Signed: _____ Date: _____

Approved: _____ Date: _____

Title : _____

PERSONAL VEHICLE MILEAGE EXPENSE

DATE	DESTINATION	PURPOSE/ INDIVIDUALS CONTACTED	ACCT. TO CHARGE	ODOMETER		MILES DRIVEN
				BEGIN	END	
					TOTAL MILES	

Acct/Program Charged	Rate/ Mile	Amount	Date	I certify that the information contained herein is true & correct.
				Signed:
				Employee
				Approved:
Totals				Supervisor

REQUEST FOR EXPENDITURE AUTHORIZATION

DATE: _____

EMPLOYEE SUBMITTING REQUEST: _____

ESTIMATED COSTS: _____

VENDOR: _____

_____

_____

PURPOSE OF EXPENDITURE: _____

_____

_____

_____

_____

ACCOUNTS / PROGRAMS TO BE CHARGED	AMOUNT	ALLOCATION BASIS
TOTAL		

REQUESTED BY: _____

TITLE: _____

APPROVED BY: _____

TITLE: _____

CHECK REQUEST

DATE: _____

EMPLOYEE MAKING REQUEST: _____

ESTIMATED AMOUNT: _____

VENDOR: _____

_____

_____

PURPOSE OF EXPENDITURE: _____

_____

_____

_____

_____

ACCOUNTS/PROGRAMS TO BE CHARGED	AMOUNT	ALLOCATION BASIS
TOTAL		

REQUESTED BY: _____

TITLE: _____

APPROVED BY: _____

TITLE: _____

(Attach original vendor invoice)

NON-EXPENDABLE PERSONAL PROPERTY
Report for the period ended August 31, 19__
(Form GC-11)

NAME OF AGENCY: _____ **REPORT PREPARED BY:** _____
ADDRESS: _____ **TITLE:** _____
_____ **DATE:** _____

a. Item Description (include Model No.)	c. Inventory No. & Serial No.	d.. Unit Cost	e. Date acquired	f. Acquired under Contract-Atth. No.	g. TDH Program	h. TDH'S % owned	i. Location

TDH 9/97

NON-EXPENDABLE PERSONAL PROPERTY
Report for the period ended August 31, 19__
(Form GC-11)

NAME OF AGENCY: ABC HEALTH DEPARTMENT **REPORT PREPARED BY:** J. C. JONES
ADDRESS: 768 NW 7th **TITLE:** EQUIPMENT INVENTORY CLERK
PARIS, TX. 74509 **DATE:** 10/11/97

a. Item Description (include Model No.)	c. Inventory No. & Serial No.	d.. Unit Cost	e. Date acquired	f. Acquired under Contract-Atth. No.	g. TDH Program	h. TDH'S % owned	i. Location
386 SX COMPUTER (DELL XK400)	345X768/ ABC # 376	$1,896.50	01/13/92	C2000429-03	COPC	100 %	WAREHOUSE
DELL JY780 COMPUTER	566ER596/A ABC #467	$2,576.37	4/14/96	7.981e+10	COPC	100 %	MAIN OFFICE RM. 301

[NAME OF AGENCY]

A financial review of your Texas Department of Health contracts is scheduled for [date].

PLEASE HAVE THE COPIES OF THE FOLLOWING INFORMATION ASSEMBLED AND AVAILABLE FOR OUR MONITOR UPON ARRIVAL AT YOU OFFICE:

CHART OF ACCOUNTS (please highlight those accounts applicable to TDH contracts)

COST ALLOCATION PLANS (where applicable) supported by an explanation of the rationale, pertinent calculations and any other information necessary for the monitor to make an informed evaluation of the plan.

PROGRAM INCOME ALLOCATION PLANS (where applicable) supported by an explanation of the rationale, pertinent calculations and any other information necessary for the monitor to make an informed evaluation of the plan.

A copy of your TRAVEL POLICY

A copy of your FIDELITY BOND (or certificate of insurance)

Copies of the DETAIL MONTHLY GENERAL LEDGERS to support the reconciliation worksheets described below.

The following contract and attachments will be reviewed:

CONTRACT #	ATTACHMENT #	QUARTER TO BE RECONCILED	TEST MONTH

Please prepare a reconciliation worksheet (example & copy attached) for each attachment for the quarter indicated above. Please complete the worksheet by[day of week & date]. If you are unable to meet this deadline, please call the monitor @ (512) 458-7520.

The sum of the monthly general ledger totals for each budget category for the attachment being reviewed should be compared to the applicable totals reflected on the Form 269a for the same quarter. If the two are not the same please prepare a detail analysis of the difference with pertinent documentation to support the differences and a written explanation for the difference.

The transactions for test months as indicated above have been selected for detail review. The monitor will need to examine the ORIGINAL SOURCE DOCUMENTS for each transaction and the CANCELED CHECK which liquidated the liability created by the transaction. Please have source documents separated by budget category and in the same order as they appear on the detail general ledger. Specific types of documents are listed below by budget category:

Personnel:

Payroll journal
Time sheets
Job descriptions

Salary authorization
Salary distribution calculations
Fringe benefits:

A listing or schedule of employer-paid benefits for each employee whose pay (all or part) was charged to the TDH contract. Please provide copies of documentation (insurance company invoices, copy of retirement plan, etc.) to support the charge for each type of benefit for each employee

Travel:

Copy of the agency's current travel policy
Travel voucher supported by receipts, etc.

Equipment:

Purchase order, receiving report and vendor's original invoice

Supplies:

Purchase order, receiving report and vendor's original invoice
Expense allocation plan if charges are made to more than one cost center

Contractual:

Original contract
Contractor's original invoice, etc

Other:

Purchase order, receiving report and vendor's original invoice

The monitor has the prerogative to broaden the scope of the review and may request supporting documentation for any transaction involving the TDH contract. Please insure that a knowledgeable person is available through out the review to answer the monitor's questions and provide additional documentation if required.

The Financial Compliance Monitor assigned to your review is [monitor's name]. If you have any questions or are unable to have the above information assembled and available for review on the above date please notify [monitor's name] as soon as you become aware of a problem. The telephone number is (512) 458-7520, or Fax # (512) 458-7736.

Grants Management Division
Texas Department of Health

RECONCILIATION

CONTRACTOR: CONTRACT #: ATTACHMENT #:

CATEGORY /ACCOUNT #	GENERAL LEDGER <--------MONTHS-------->			GENERAL LEDGER TOTALS	AS REORTED ON 269A	DIFF.	NOTE #

A6 (con't)

SPECIAL REQUIREMENTS FOR MATCHING CONTRACTS

IN GENERAL

Some TDH cost-reimbursable contracts requires the recipient to provide a proportionate share of the funding for the project. The categorical budgets for these contracts will include TDH's share of the funding plus the recipient's matching share of the total project funding.

If the contractor does not contribute a sufficient match, TDH's funding for the contract will be reduced proportionately to maintain the required matching ratio.

The NATURE of MATCHING COSTS

The contractor's share of costs for matching contracts may consist of any combination of the following categories of costs:

Unreimbursed cash expenditures: Allowable expenses incurred by the contractor in the performance of the contract's scope of work and which are funded with the contractor's own unrestricted funds.

Contractor's non-cash expenditures: Allowable expenses which do not require a cash outlay during the contract term. An example of a non-cash expenditure is depreciation on equipment purchased with non-TDH funds and used in performing the scope of work of the contract.

Third party in-kind contributions: Items such as volunteer services, donated supplies, loaned equipment, donated office or storage space, etc. which must meet the following criteria to be acceptable as match:

Must be necessary to accomplish the scope of work as described in the contract

Must meet all the requirements of allowable costs per UGMS

Must be valued at the local market value for equal or similar goods or services

Must be adequately documented. Documentation should include: (a) a description of the goods or services contributed; (b) the purpose of the goods or service as related to contract performance, (c) the basis for determining value and supporting calculations and documentation, (d) time sheets, if volunteered personal services; and (e) any additional documentation necessary to authenticate the transaction.

The value of the in-kind contributions must be recorded in the contractor's official accounting records in a unique set of accounts and reported as contract costs in the required Financial Status Report (FSR) Form 269a.

REIMBURSEMENT REQUESTS for COSTS INCURRED

The contractor may submit monthly State of Texas Purchase Vouchers for reimbursement of the TDH's share of the allowable costs incurred in the performance of the contract. Expenses "funded" by in-kind contributions are not reimbursable expenses and this factor must be considered when preparing monthly reimbursement requests. Form B-13A is for this purpose. Each reimbursement request (TDH Form B13 - State of Texas Purchase Voucher) for a Matching contract attachment must be submitted with and supported by a completed TDH Form B-13A. A copy of this form is attached.

CASH ADVANCES

The General Provisions of TDH contracts allow contractors to request cash advances. These advances must be repaid by the end of the contract attachment term. Repayment is accomplished by reducing reimbursement requests. The reductions may be made through out the term of the attachment or during the final three months. If repayment is to be made during the last 3 months, 1/3 of the total advance must be repaid each of the 3 months. The cumulative amount of the advance repaid must be reflected on line #11 of Form B-13A.

FINANCIAL STATUS REPORTS

The quarterly FSR Form 269A should reflect the total costs incurred in performance of the contract's scope of work. Total costs includes cash, non-cash, and In-Kind.

MATCHING CONTRACTS
Supporting Schedule for Reimbursement Requests

This form is to accompany reimbursement requests (TDH Form B-13 - State of Texas Purchase Voucher) for TDH contract attachments which have a mandatory cost match requirements.

1	**Total cumulative allowable costs incurred to date (excluding In-Kind)**	**$**
2	**Total value of third party In-Kind contributions to project effort**	
3	**Total cumulative project costs thru _____ (Line 1 + Line 2)**	**$_____**
4	**Contractor's required match (___% of total cumulative project costs - Line 3 above)**	**$**
5	**Less: In-Kind contributions from Line 2 above**	
6	**Subtract Line 5 from Line 4 - if the result is a negative amount enter it on Line 8 below**	**$_____**
7	**TDH's maximum contribution (___% of total cumulative project costs from Line 3)**	**$**
8	**Less: Negative amount (if any) from Line 6 above**	
9	**Cumulative reimbursable expenses (amount on Line 7 reduced by amount entered on Line 8)**	**$_____**
10	**Less: Total of previous reimbursement requests**	
11	**Less: Cumulative amount of advance repaid**	
12	**Reimbursement requested (Line 9 less Line 10 & 11). Enter this amount in the appropriate column on Form B-13 (State of Texas Purchase Voucher)**	**$_____**

INSTRUCTIONS FOR TDH FORM B-13A:

Line No.	Instructions
1	Enter the total cumulative allowable costs (cash & non-cash - see note below) incurred on the attachment from its effective date through the final day of the period covered by this reimbursement request.
2	Enter the total value of the allowable in-kind contributions received through the period covered by the reimbursement request
3	Enter the sum of line 1 and 2.
4	Enter the product of multiplying the sum reflected on line 3 by the percentage the contractor must contribute.
5	Enter the amount reflected on line 2 above.
6	Subtract line 5 from line 4 and enter results here. If line 5 is greater than line 4 enter the negative difference on line 8.
7	Multiply line 3 by TDH percentage share of the contract.
8	If line 6 is negative, enter the negative amount here. If line 6 is positive, leave blank.
9	Subtract the amount reflected on line 8 from line 7
10	Enter the cumulative total of reimbursement requests submitted in prior months. Do not include the amount of advance payment requested and received (if any).
11	Enter the cumulative amount of the advance which has been or is being repaid (if any). Note: Advances must be repaid by the end of the Attachment term.
12	Subtract the amounts reflected on lines #10 & 11 from line 9 and enter the result here and on the face of the Form B-13 - Purchase Voucher. This is the amount to be reimbursed by TDH.

Note An example of an allowable non-cash expenditures would be the depreciation recognized on a piece of equipment purchased by your agency in a prior year and currently being used on this Attachment.SUGGESTED COST ALLOCATION METHODS

TYPE OF EXPENSE	SUGGESTED BASES FOR ALLOCATION
Traditional Methods	

Employee's gross salary (includes vacation, holiday, sick leave and other paid time-off)	Hours worked by cost center, functions, programs, contract attachments, etc. as reflected on employee's timesheet for the pay period - must be based on actual hours for each pay period and actual pay for the same
Employer's FICA & Medicare taxes	Allocated salary expense
Health Insurance	By covered employee
Workman's Comp Insurance	Covered employee's allocated salaries based employee classification
Fidelity bond premium	Covered employee's allocated salaries
Vacation, holiday, sick leave and other non-productive paid time	Allocated as a part of employee's gross salary
Building rent	Square feet of space assigned to specific functions, cost centers, programs, contract attachments, etc
Utilities	
Building Insurance	
Janitorial Service	
Building repairs & maint.	
Copier rental, copier paper & copier supplies	Number of copies made by cost center, functions, programs, contract attachments, etc.
Telephone expenses except long distance charges (equipment rental, basic monthly charge,etc.)	Number of instruments assigned to cost centers, functions, programs, contract attachments, etc.
Equipment rental, repairs & maintenance	Allocate based on usage
Audit expense	Audit hours
Non-Traditional Methods(require TDH's pre-approval for charges to TDH contracts)	
Salaries, payroll taxes, and other payroll related expenses	Number of actual full time equivalent employes per cost center, function, programs, etc per pay period
Salaries, payroll taxes, and other payroll related expenses	Number of specific type of clients/patients served as related to total number of all types of patients served

Rent, utilities, general office supplies, and other expenses with a reasonable relationship to number of employees	Number of actual full time equivalent employes per cost center, function, programs, etc per pay period ----or--- Number of specific type of clients/patients served as related to total number of all types of patients served ----or--- Salaries charged to a cost center, function, programs, etc per pay period

Occupancy Expenses

1. Occupancy Expenses will consist of the following expense categories:
   - ➜ Building rent
   - ➜ Utilities (electric, gas, water, and waste)
   - ➜ Janitorial services
   - ➜ General building repairs & maintenance
2. Occupancy Expense will be allocated on the basis of square footage of floor space assigned to individual programs.
3. The calculations of the allocation basis will be recomputed each time the allocated floor space changes.

Determination of Allocation Factors

Program or Cost Center	Assigned Sq. Ft. (1)	Allocation Factor
Program "A"	750	**23%**
Program "B"	1500	**45%**
Program "C"	550	**17%**
Administration	500	**15%**
	3300	100%

Example - A Month's Expenses to be Allocated

Expense	Amount
Rent	$3,000.00
Electric	200.00
Gas	50.00
Water	65.00
Waste	25.00
Janitorial	300.00
Repairs & Maint.	175.00
Total expenses to allocate	$3,815.00

Example - Workpaper for Allocating Above Expenses

	Allocation Factor	Expense to Allocate	Allocated Expenses
Program "A"	0.23	$3,815.00	$867.05
Program "B"	0.45	$3,815.00	$1,734.09
Program "C"	0.17	$3,815.00	$635.83
Administration	0.15	$3,815.00	$578.03
		Allocated Expenses	**$3,815.00**

(1) Assigned square feet does not include common space such as reception area, employee breakroom, restrooms, conference room, halls, etc. Expenses related to these areas are included in the total occupancy expense categories and will be allocated to each Program and Administration

Copying Expenses

1. The following expenses relating to the operation and maintainence of the copying machine will be charged to the expense category "Copy Center Expense".

   - ➜ Copy machine rental
   - ➜ Copier paper
   - ➜ Toner
   - ➜ Repairs and maintenance

2. A detail log will be maintained at the copy machine, an entry to be made each time the machine is used. This log will reflect the following information for each time copies are made:

   - ➜ Date
   - ➜ Initial of individual making the copies
   - ➜ Program or cost center to be charged
   - ➜ Number of copies made

3. The cumulative expenses for the period (see (a) below) will be divided by the total number of copies made during the period to determine the cost per copy, determine the number of copies charged to each program or cost center and multipy by the cost per copy to determine the charge to each program and cost center for the period.

Determination of Allocation Factors

Program or Cost Center	Assigned Sq. Ft. (1)	Allocation Factor
Program "A"	750	**23.00%**
Program "B"	1500	**45.00%**
Program "C"	550	**17.00%**
Administration	500	**15.00%**
	3300	100.00%

Example - A Month's Expenses to be Allocated

Expense	Amount
Copy Center expenses	$376.20
Number of copies made this mo.	3,300
Cost per copy	**11.4¢**

Example - Workpaper for Allocating Above Expenses

	Number of copies	Costs per copy	Total Charges
Program "A"	1752	0.114	$199.73
Program "B"	758	.114	86.41
Program "C"	124	.114	14.14
Administration	666	.114	75.92
Allocated Expenses	3300		$376.20

LABOR DISTRIBUTION for TDH GRANTS

The basic formula to be used to distribute an employee's pay for a specific pay period to a TDH grant attachment is as follows:

$$\textit{TOTAL GROSS PAY FOR PERIOD} \times \frac{\textit{TOTAL HOURS WORKED ON ATTACHMENT DURING PERIOD}}{\textit{TOTAL DIRECT HOURS WORKED DURING PERIOD}}$$

Assume that :

1. The payroll journal reflects that employee "A" is paid a gross salary of $750 for the week ending 7/5/96.

2. A's time sheet for the week is as follows:

Activity	M 1	T 2	W 3	T 4	F 5	S 6	S 7	TOTAL HOURS
TDH ATTACH #1	4		4		4			12
TDH ATTACH #2		8						8
TCADA GRANT	4							4
TOTAL DIRECT HRS	8	8	4		4			24
VACATION					4			4
SICK LEAVE			4					4
HOLIDAY				8				8
TOTAL HRS PAID	8	8	8	8	8			40

   Hours worked on TDH Attachment #1 = 12

   Hours worked on TDH Attachment #2 = 8

   Total direct hours worked = 24

3. The distribution calculations for A's pay to the TDH's attachments would be as follows:

   #1 = 12/24 X $750 = $375.00

   #2 = 8/24 X $750 = $250.00

4. The amounts calculated above would be posted to separate general ledger accounts for each attachment.

A clear audit trail with supporting documentation must be provided so that each step outlined above can be easily identified, analyzed, and , if necessary, reconstructed.